Health Care for the Homeless Network
A Community Project of Public Health—Seattle & King County

2003 Annual Report

Mission:

Health Care for the Homeless Network (HCHN) provides quality, comprehensive health care for people experiencing homelessness in King County, and provides leadership to help change the conditions that deprive our neighbors of home and health.

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Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Health Care for the Homeless Network Advisory Planning Council

Carole Antoncich, Homeless Housing Coordinator, King County Department of Community and Human Services

Maureen Brown, MD, Swedish Family Practice Residency Program – Downtown Public Health Center

Letitia Colston MSW, Naturopathic medicine student

Mark Dalton, Administrator, Washington State Dept. of Social and Health Services, Belltown Community Service Office

Sinan Demirel, Executive Director, Rising Out of the Shadows

Charissa Fotinos, **MD**, Medical Director, Public Health—Seattle & King County

Rick Friedhoff, Executive Director, The Compass Center

Kerry Holifield, Consumer Representative

Ronald L. Johnson, Consumer Representative

Kristi Linsenmayer, DDS, Seattle Indian Health Board

Angela Morales, Lead Case Manager, Hopelink Transitional Housing

Sandy Olson, Clinic Practice Manager, Pioneer Square Clinic Harborview Medical Center

Alan Painter, Director, Community Services Division, City of Seattle Human Services Department

Linda Rasmussen, Regional Director, South King County, YWCA of Seattle, King County & Snohomish County

Danine Tucker, Consumer Representative

Patrick Vanzo, Cross-Systems Integration Administrator, KC Dept. of Comm. & Human Services

Linda Weedman, Director of Housing & Related Services, YWCA of Seattle, King County & Snohomish County

HCHN 2003 Partners Agencies

Health Care for the Homeless Network (HCHN) is grateful to the many community-based organizations and fellow Public Health programs that share a commitment to helping improve access to health care for people experiencing homelessness. In 2003, HCHN contracted over $3 million to community agencies and is proud to partner with them in their innovative programs to improve access to and quality of care for homeless people.

- Country Doctor Community Health Centers
- Community Health Centers of King County
- Evergreen Treatment Services
- Pike Market Medical Clinic
- Pioneer Square Clinic – Harborview
- Puget Sound Neighborhood Health Centers
- Public Health Tuberculosis Control Program
- Seattle Indian Health Board
- UW Adolescent Medicine Clinic
- Valley Cities Counseling & Consultation
- Salvation Army's William Booth Center
- YWCA of Seattle-King-Snohomish County
- Odessa Brown Children's Clinic
- Public Health Clinics and Programs

2003 MAJOR ACCOMPLISHMENTS

Improved Access to Health Care for Homeless People

Through the contractual partnerships that constitute the Health Care for the Homeless Network, 8,037 unduplicated homeless people accessed 43,621 health care related visits in 2003. Most visits take place in shelters, day centers, and other homeless program sites. We estimate that the Network has some type of contact with about one-third of the homeless population in King County over the course of a year.

> *"Shanna and Linda are approachable and easy to talk to . . they offer an immense source of referrals for further care, and even help clients without benefits access prescriptions and medical equipment…they are part of our team. – Staff of Domestic Abuse Women's Network*
>
> [Shanna Hanft, RN, and Linda McDermott, ARNP are with Community Health Centers of King County and visit homeless programs outside Seattle.]

> ***"****Marc and Keith continue to help meet the needs of homeless people who are not eligible for the King County Mental Health Plan . . . they will continue to have no shortage of work."*
> *- Staff of the Downtown Emergency Service Center.*
>
> [Marc Potter and Keith Johannes are mental health professionals with Pioneer Square Clinic, and are sited at the Downtown Emergency Service Center.]

Additionally, Public Health clinics and field nurses provided care for 13,739 unduplicated homeless people, those living in temporary "doubled up" situations, and those at high risk of recurring homelessness. Sixty-five percent were female, reflecting Public Health's large parent-child program. Public Health works intensively with pregnant and post-partum homeless women. Other Public Health programs serving significant numbers of homeless people include the TB Control Program, Sexually Transmitted Disease program, and HIV/AIDS services.

Medical Respite Program Serves Highly Vulnerable Adults

The 22-bed *Medical Respite* Program is operated by Harborview Medical Center's Pioneer Square Clinic. Beds for men are at the Salvation Army's William Booth Center, and for women at the YWCA downtown shelter.[1] Respite provides shelter, food, nursing care, and help finding housing for homeless people who need a place to recuperate.

- 378 clients were admitted in 2003. Of them, 274 clients (72%) were chronically homeless with a disabling mental health/chemical dependency condition.
- Respite Program met its objectives: 44% of clients completing their stay obtained an improved housing situation (goal = 35%); 94% of clients received a psychosocial assessment (goal = 75%).

In September 2003, HCHN hosted the national Respite Program conference in downtown Seattle. HCHN single adult services coordinator Trudi Fajans organized the successful gathering, which drew representatives from cities nationwide.

[1] Women's beds are being moved to YWCA Opportunity Place – Angeline's in 2004.

Shelter Health & Safety Program Help Prevent the Spread of Communicable Diseases

Support for Homeless Agencies

Public Health Nurse Heather Barr provided over 30 training and education sessions for staff and clients of homeless agencies. She also distributed respiratory hygiene ("cover your cough") posters and related supplies to homeless agencies.

> "*I have attended two excellent training sessions by Heather Barr regarding lice and TB . . very informative, relevant, and insightful*." - Shelter staff person

Ms. Barr also gave over 1,000 flu shots at King County homeless shelters, day centers, and housing programs for formerly homeless people.

> *"A few tenants with chronic illnesses had planned on "hoping for the best" ... the Public Health nurse coming to our building to administer flu shots allowed people to protect their health without being forced to choose between medicine and food."* - Housing agency staff

Emergency Preparedness Supplies

Using special funds available for emergency preparedness purposes, HCHN purchased $20,000 in supplies such as water, food, first aid kits, flashlights, and radios for homeless shelters in King County.

Housing is Health Care: Long-Term Case Management Programs Help Clients Stabilize

REACH Case Management for Chronic Public Inebriates

REACH is a program of Evergreen Treatment Services and Pike Market Medical Clinic, providing case management and health services to repeat users of the Sobering Support Center. In 2003, REACH worked with 147 individuals.

- REACH met its objectives in 2003: 69% of REACH clients improved or maintained their housing (goal = 40%), and 60% accessed substance abuse treatment services (goal = 30%).
- REACH clients were hit hard by a TB outbreak that began in 2002: 27 clients had TB in 2002-03, and REACH staff helped support them through the long treatment period, working closely with the Public Health TB Control Program.

Pathways Home Medical Case Management for Homeless Families

Pathways Home is a HUD-funded program that provides multidisciplinary therapeutic case management to homeless children and families wherever they are in King County. It is a program of Valley Cities Counseling & Consultation and Puget Sound Neighborhood Health Centers.

- In 2003, the team served 95 families (95% of goal) and maintained caseload at any given time at or above the expected level of 45 families.
- Housing achievements were significant, with 48% of families moving up the housing continuum (goal of 50%) and 30% more moving into permanent housing (goal of 20%).

Intensive Efforts to Control a Tuberculosis Outbreak Among Homeless People

HCHN worked closely with the Public Health TB Control Program to control a TB outbreak among homeless single adults in downtown Seattle. The outbreak began in 2002 (30 cases of active TB among homeless) and continued into 2003 (35 cases). Of the 65 cases in 2002-03, 40% were Native American.

- We trained homeless agency staff and homeless people on TB symptoms, and assisted with contact investigations.
- We established a "Homelessness & TB Coalition" with community-based homeless agencies to coordinate work on the TB outbreak and begin work on TB Guidelines for homeless agencies.
- We held a focus group with 11 homeless Native American people with TB to better understand their experiences and improve our services (organized in conjunction with American Lung Association of Washington).

Quality Improvement

- HCHN sponsored 5 training sessions for providers working with homeless people, organized by Laurie Becker. Trainings help ensure up-to-date knowledge on relevant topics and promote best practice approaches in working with clients:
  – Infectious Diseases Update (TB, SARS, Pertussis, & West Nile Virus)
  – Smoking Cessation & Homelessness
  – Fetal Alcohol Effect & Fetal Alcohol Syndrome
  – HIV/AIDS Update
  – Motivational Interviewing Techniques
- HCHN re-established its Quality Management committee in 2003. It is chaired by HCHN Planning Council member Sandy Olson and staffed by HCHN clinical lead, Susan Kline, ARNP. It brings together knowledgeable practitioners who oversee the quality assurance activities across the Network, such as chart reviews, client satisfaction surveys and focus groups, and data collection.
- In 2003, HCHN staff served on national and local groups working toward ending homelessness, including the Seattle-King County Coalition for the Homeless, Safe Harbors Advisory Committee, Committee to End Homelessness in King County, and the National Health Care for the Homeless Council and Clinician's Network.

HCHN thanks the following, whose support totaled over $4 million in 2003.

U.S. Department of Health & Human Services – Bureau of Primary Health Care
U.S. Department of Housing & Urban Development
City of Seattle and King County governments
Phoebe W. Haas Charitable Trust B
Private Donors / Contributions of Supplies & Services (2003):
Katherine King
Ken Kraybill, National Health Care for the Homeless Council
Pru Sulzer
Small Changes (magazine & calendar distributor)

Health Care for the Homeless Network - SERVICE SITES 2003

Single Adults

Chief Seattle Club
Compass Center & Compass Cascade
Downtown Emergency Services Center
Pioneer Square Clinic
Seattle Indian Health Board
Dutch Shisler Sobering Support Center
St. Martin de Porres Shelter
Salvation Army William Booth Center (Respite care site)
Second Avenue Clinic (next to Needle Exchange)
Katherine's House
YWCA - Angeline's Day Center; Downtown YWCA (Respite care site)
Other sites: streets, parks, campgrounds, cars etc.

Unattached Youth

45th Street Clinic (Puget Sound Neighborhood Health Centers)
County Doctor Youth Clinic (via UW Adolescent Medicine clinic)
Eastside Community Youth Clinic (Community Health Centers of King County)
YouthCare Orion Center
YMCA The Landing Teen Shelter (Bellevue)

Families

Broadview Shelter – Fremont Public Association
Catherine Booth House – Salvation Army
Community Health Centers of King County
Domestic Abuse Women's Network
Eastside Domestic Violence Program
First Place School
Hopelink sites
Jubilee House
South King County Multi-Service Center sites
YWCA family sites countywide
Other sites: streets, parks, campgrounds, cars etc.
New Beginnings
Our Place Day Care
Providence Hospitality House
Rose of Lima
Sacred Heart
Seattle Emergency Housing Services
Union Gospel Mission
Morningsong Family Support Center

ABOUT THE DATA

Note: Data presented in this report includes visit data reported by all HCHN contractors for all programs and all sites. Visits are provided by medical, mental health, chemical dependency, and case management staff.

- ***Client Demographics***: The profile of homeless people served through HCHN has not shifted from previous years. The majority are people of color, and about half lack any type of health care coverage.
- ***Health problems***. Across all subpopulations—adults, families, and children, and youth—mental health problems are dominant, often with co-occurring substance abuse disorders. The Network's health care providers report increasing levels of untreated mental health issues because so few people are eligible for publicly funded mental health services. This is making it all the more difficult to address physical health conditions. Also common are acute health problems, upper respiratory conditions, skin disorders, and chronic conditions such as heart-related problems and diabetes.

CLIENT DEMOGRAPHICS

Total 2003 Unduplicated HCHN Clients: 8,037
Total 2003 Visits: 43,621

		Number	Percent
AGE			
	0 through 5	463	6%
	6 through 10	236	3%
	11 through 13	122	2%
	14 through 17	391	5%
	18 through 34	2,224	28%
	35 through 59	4,103	51%
	60 through 74	452	6%
	75 through 84	44	1%
	85+	2	0%
	Total	**8,037**	**100%**
RACE/ETHNICITY			
	Asian/Pacific Islander	236	3%
	African American	2,034	25%
	American Indian/AK Native	653	8%
	Hispanic or Latino	805	10%
	Multi-racial	607	8%
	People of color total	*4,335*	*54%*
	Caucasian	3,636	45%
	Race unknown or not reported	66	1%
	Total	**8,037**	**100%**
GENDER			
	Male	4,600	57%
	Female	3,437	43%
	Total	**8,037**	**100%**
HOUSEHOLD TYPE/SOCIAL UNIT			
	Single Adults	5,472	68%
	Unattached Youth	513	6%
	Family	1,897	24%
	Unknown	155	2%
	Total	**8,037**	**100%**
HOUSING STATUS			
	Street	522	6%
	Shelter	3,178	40%
	Transitional	572	7%
	Doubled Up	468	6%
	Other	990	12%
	Unknown	2,307	29%
	Total	**8,037**	**100%**
INSURANCE			
	Medicaid	2,993	37%
	No insurance or unknown	4,014	50%
	Other Public Assistance	468	6%
	Medicare	439	5%
	Private Insurance	123	2%
	Total	**8,037**	**100%**

Number & Percent of 2003 HCHN Patients With Selected Health Problems, by Subpopulation

Note: A user may have more than one problem

Health Problem	Children	% with this Problem	Rank	Unattached Youth	% with this Problem	Rank	Family Adults	% with this Problem	Rank
Abuse Issues	104	13%		59	12%		279	25%	2
Acute Health Problems	100	13%		154	30%	3	126	11%	4
Asthma	65	8%		33	6%		42	4%	
Chemical Dependency	9	1%		145	28%	4	163	15%	3
Chronic Bronchitis/Emphysema/COPD	1	0%		2	0%		13	1%	
Dental	108	14%		10	2%		78	7%	
Developmental Disorders	54	7%		15	3%		9	1%	
Diabetes	1	0%		3	1%		41	4%	
GI Disorder	51	7%		17	3%		53	5%	
Heart/Circulation Problems	5	1%		8	2%		82	7%	
Mental Health Issues	310	40%	2	398	78%	1	621	56%	1
Musculo Skeletal Disorders	16	2%		103	20%	5	113	10%	5
Preventive Health / Screenings	385	49%	1	198	39%	2	116	10%	
Immunizations	141	18%	5	45	9%		47	4%	
Skin Disorders (includes cellulitis & abscess)	158	20%	4	101	20%		70	6%	
STD (includes HIV/AIDS)	2	0%		40	8%		12	1%	
Upper Respiratory/Otitis Media	178	23%	3	88	17%		76	7%	
Other Medical Conditions	*258*			*273*			*444*		
Undup. Users in This Subpopulation	784			513			1113		

Number & Percent of 2003 HCHN Patients With Selected Health Problems, by Subpopulation, continued

Note: A user may have more than one problem

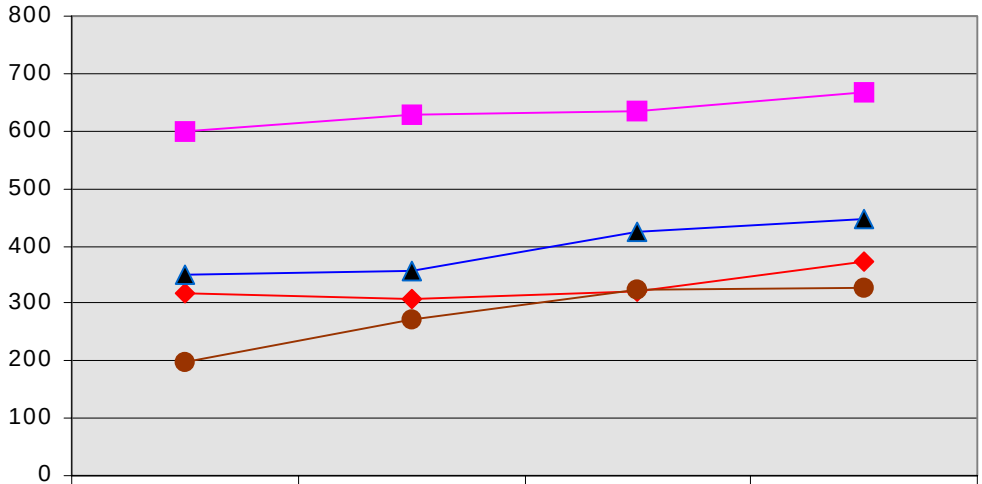
Health Problem	Single Men	% with this Problem	Rank	Single Women	% with this Problem	Rank	TOTAL ALL GROUPS	% with this Problem	Rank
Abuse Issues	23	1%		238	13%		703	9%	
Acute Health Problems	882	24%	3	461	25%	2	1723	22%	4
Asthma	96	3%		148	8%		384	5%	
Chemical Dependency	994	27%	2	450	25%	3	1761	22%	3
Chronic Bronchitis/Emphysema/COPD	121	3%		54	3%		191	2%	
Dental	112	3%		58	3%		366	5%	
Developmental Disorders	8	0%		20	1%		106	1%	
Diabetes	305	8%		99	5%		449	6%	
GI Disorder	441	12%		207	11%		769	10%	
Heart/Circulation Problems	590	16%		209	11%		894	11%	
Mental Health Issues	788	22%	4	862	47%	1	2979	38%	1
Musculo Skeletal Disorders	735	20%	5	350	19%		1317	17%	5
Preventive Health / Screenings	311	9%		185	10%		1,195	15%	
Immunizations	138	4%		82	5%		453	6%	
Skin Disorders (includes cellulitis & abscess)	1118	31%	1	405	22%	4	1852	23%	2
STD (includes HIV/AIDS)	113	3%		84	5%		251	3%	
Upper Respiratory/Otitis Media	620	17%		355	20%	5	1317	17%	5
Other Medical Conditions	*1415*			*863*			*3253*		
Undup. Users in This Subpopulation	3652			1820			7882		

Note: Total Unduplicated Users in 2003 was 8,037.
Household status unknown for 155 individuals, and data on them is not included in this analysis

Changes in Selected Health Problems Among HCHN Clients

Number of HCH Users With Selected Problems, 2000-2003

Note: # of users each year remained constant at about 8,000 people



	2000	2001	2002	2003
Asthma	316	309	321	373
Hypertension	599	627	634	667
Diabetes	351	355	424	446
Nutrition Problem	196	273	324	326

How Many Had HCHN Visits in Each Year of the Last 4 Years?

HCHN is particularly interested in understanding the dynamics of long-term homelessness and working with other housing and service agencies to move these individuals into stable housing. Toward that end, we analyzed the group of people who are "repeat" clients from one year to the next. We asked: **Of the 8,037 clients who had an HCH visit in 2003, how many of them also had an HCHN visit in 2002 *and* 2001 *and* 2000?** (Any type of visit with any type of provider.) We found that **828** people met this criteria. This is 10% of the overall population served by HCHN in 2003. Compared to the overall HCH population, this group was much more likely to be single adult males.

	Gender		
AGE (in 2003)	**Female**	**Male**	**Total**
4 and under	0	0	0
5 through 12	2	2	4
13 through 19	15	4	19
20 through 44	111	120	231
45 through 74	113	444	557
75+	6	11	17
Total	**247**	**581**	**828**
	30%	**70%**	

Note: one person in the 20-44 category is male to female transgendered & counted as female

RACE		
Native Am/ Alaska Native	127	15%
Asian	20	2%
African American	203	25%
Hispanic (all races)	71	9%
Multi-racial	23	3%
Other	1	0%
White	381	46%
Unknown	2	0%
	828	**100%**

MEDICAL INSURANCE (as of first encounter of 2003)		
Medicaid	316	38%
Medicare	166	20%
Other Public Insurance	36	4%
Private	17	2%
No insurance	290	35%
Unknown/Missing	3	0%
	828	**100%**

HOUSEHOLD STATUS (as of first encounter of 2003)		
Single Adults	769	93%
Unattached Youth	19	2%
Family	40	5%
	828	**100%**

Selected Health Problems of This Group of 828 Clients

Health Problem Group	2000	2001	2002	2003	% with this problem in 2003
Acute Health Problem	328	322	301	259	**31%**
Skin Disorders	311	282	266	251	**30%**
Substance Abuse Disorders	345	354	337	249	**30%**
Heart/Circulation	267	267	270	235	**28%**
Mental Health	258	283	246	213	**26%**
Musculo-Skeletal Disorders	243	226	239	204	**25%**
Upper Respiratory/Otitis Media	242	207	188	161	**19%**
Social/Basic Needs/Entitlements	157	133	136	149	**18%**
Diabetes	120	120	136	137	**17%**
GI Disorders	170	183	175	136	**16%**
Chronic Bronchitis /Emphysema/COPD	54	71	66	53	**6%**
Asthma	67	61	66	42	**5%**
Abuse Issues	88	50	48	36	**4%**
STD/HIV/AIDS	39	28	28	21	**3%**
Dental	56	53	41	23	**3%**
Developmental Disorders	11	10	10	9	**1%**
Other	*477*	*447*	*490*	*434*	***52%***

Total 2000-2003 visits by this group was 38,043. Average 11.5 visits/year per client.

Planning Implications. Among those with clearly long histories of homelessness, we see the need to plan outreach, health, and housing responses that take into account the following:

- Particularly high levels of **substance abuse** disorders and co-occurring substance abuse/mental health disorders.
- The presence of **chronic health conditions**, most often heart problems and diabetes. Among all HCH users in 2003, 6% had diabetes, compared to 17% among this group of long-term homeless people. A national study found 46% of homeless people have one or more chronic health conditions. [2]
- The need for **culturally appropriate** services. In this group, the percent who are Native American (15%) is notably higher than their percentage of the total HCH users (8%).

[2] Burt, Martha. *Helping America's Homeless*, Washington, DC: Urban Institute, 2001